



GEORGIA MEDICAID FEE-FOR-SERVICE HEREDITARY ANGIOEDEMA (HAE) TREATMENTS PA SUMMARY

Preferred	Non-Preferred
Berinert (C1 esterase inhibitor [human]) Firazyr (icatibant) Haegarda (C1 esterase inhibitor [human]) Icatibant generic Orladeyo (berotralstat)*	Cinryze (C1 esterase inhibitor [human]) Kalbitor (ecallantide)^ Ruconest (C1 esterase inhibitor [recombinant]) Takhzyro (lanadelumab-flyo)

*preferred but requires PA; ^non-preferred but does not require PA

LENGTH OF AUTHORIZATION: 1 year

NOTES:

- **The criteria details below are for the outpatient pharmacy program.** If a medication is being administered in a physician's office or clinic, then the medication must be billed through the DCH physician services program and not the outpatient pharmacy program. Information regarding the physician services program is located at www.mmis.georgia.gov.
- Orladeyo is preferred but requires prior authorization. Kalbitor is non-preferred but does not require prior authorization.

PA CRITERIA:

Orladeyo

- ❖ Approvable for members 12 years of age or older with a diagnosis of hereditary angioedema (HAE) to prevent attacks who have experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with Haegarda.

Cinryze

- ❖ Approvable for members 6 to 11 years of age with a diagnosis of HAE for prophylaxis to prevent attacks who have experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with Haegarda.
- ❖ Approvable for members 12 years of age or older with a diagnosis of HAE for prophylaxis to prevent attacks who have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with Haegarda and Orladeyo.
- ❖ Approvable for members 18 years of age or older with a diagnosis of HAE for treatment of acute attacks who have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with Berinert and icatibant (Firazyr).

Ruconest

- ❖ Approvable for members 13 years of age or older with a diagnosis of HAE for treatment of acute attacks who have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with Berinert and icatibant (Firazyr).

Takhzyro



- ❖ Approvable for members 2 to 5 years of age with a diagnosis of HAE for prophylaxis to prevent attacks.
- ❖ Approvable for members 6 to 11 years of age with a diagnosis of HAE for prophylaxis to prevent attacks who have experienced an inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect with Haegarda.
- ❖ Approvable for members 12 years of age or older with a diagnosis of HAE to prevent attacks who have experienced an inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects with Haegarda and Orladeyo.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on [Other Documents](#), then select the most recent quarters QLL list.